MONTANA LEGISLATIVE HISTORY

Chapter _____ ~~19~~ 2005

Bill H _____ S 440 Original bill & history X C

H. Committee on ~~P~~ HUMAN SERVICES

Hearing Date(s)	3/21	X	C
EXEC ACTION	4/4	X	C
			C
			C
Date Out			C

S. Committee on PUBLIC HEALTH WELFARE & SAFETY

Hearing Date(s)	2/16	X	C
EXEC ACTION	2/16	X	C
			C
			C

Did this bill originate in an interim committee? ____Yes ____No

Committee _____ Report _____

LEGISLATIVE HISTORIES SINCE 1997

The scope and depth of legislative committee minutes varies by year and by committee. If you would like additional information about a hearing, you may want to determine whether the hearing was recorded. In addition, some recent floor debates were also recorded. For information on accessing or purchasing these recordings, contact the Historical Society Archives at 406-444-4774.

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Bill Draft Number: LC1405
Bill Type - Number: SB 440
Short Title: Require licensure of specialty hospitals
Primary Sponsor: Dan Harrington

Bill Actions - Current Bill Progress: Became Law

Bill Action Count: 51

Action - Most Recent First	Date	Votes Yes	Votes No	Committee
Chapter Number Assigned	04/22/2005			
(S) Signed by Governor	04/21/2005			
(S) Transmitted to Governor	04/12/2005			
(H) Signed by Speaker	04/11/2005			
(S) Signed by President	04/11/2005			
(S) Returned from Enrolling	04/09/2005			
(C) Sent to Printing	04/08/2005			
(S) Sent to Enrolling	04/07/2005			
(H) Returned to Senate	04/06/2005			
(H) 3rd Reading Concurred	04/06/2005	86	14	
(H) Scheduled for 3rd Reading	04/06/2005			
(H) 2nd Reading Concurred	04/05/2005	86	14	
(H) Scheduled for 2nd Reading	04/05/2005			
(H) Committee Report--Bill Concurred	04/05/2005			(H) Human Services
(H) Committee Executive Action--Bill Concurred	04/05/2005	16	0	(H) Human Services
(H) Hearing	03/21/2005			(H) Human Services
(H) Referred to Committee	03/07/2005			(H) Human Services
(H) First Reading	03/07/2005			
(S) Transmitted to House	02/23/2005			
(S) 3rd Reading Passed	02/23/2005	36	14	
(S) Scheduled for 3rd Reading	02/23/2005			
(S) 2nd Reading Passed	02/22/2005	32	17	
(S) Scheduled for 2nd Reading	02/22/2005			
(C) Sent to Printing	02/21/2005			
(S) Committee Report--Bill Passed as Amended	02/21/2005			(S) Public Health, Welfare and Safety
(S) Committee Executive Action--Bill Passed as Amended	02/21/2005	7	2	(S) Public Health, Welfare and Safety
(S) Hearing	02/16/2005			(S) Public Health, Welfare and Safety

(S) Fiscal Note Printed	02/16/2005	
(S) Fiscal Note Signed	02/15/2005	
(S) Fiscal Note Received	02/15/2005	
(S) Fiscal Note Requested	02/11/2005	
(S) Referred to Committee	02/11/2005	(S) Public Health, Welfare and Safety
(S) First Reading	02/11/2005	
(C) Introduced Bill Text Available Electronically	02/10/2005	
(S) Introduced	02/10/2005	
(C) Draft Delivered to Requester	02/10/2005	
(C) Draft Ready for Delivery	02/10/2005	
(C) Draft in Assembly/Executive Director Review	02/09/2005	
(C) Draft in Final Drafter Review	02/09/2005	
(C) Bill Draft Text Available Electronically	02/09/2005	
(C) Draft in Input/Proofing	02/09/2005	
(C) Draft to Drafter - Edit Review [CAJ]	02/08/2005	
(C) Draft in Edit	02/08/2005	
(C) Draft in Legal Review	02/08/2005	
(C) Draft Taken Off Hold	02/08/2005	
(C) Draft On Hold	01/17/2005	
(C) Draft to Requester for Review	01/17/2005	
(C) Draft to Requester for Review	01/17/2005	
(C) Draft Taken Off Hold	01/17/2005	
(C) Draft On Hold	12/09/2004	
(C) Draft Request Received	12/01/2004	

Sponsor, etc.

Sponsor, etc.	Last Name/Organization	First Name	Mi
Requester	Harrington	Dan	
Drafter	Niss	David	
Primary Sponsor	Harrington	Dan	

Subjects

Description	Revenue/Approp.	Vote Majority Req.	Subject Code
Health Care Services (see also: Health)		Simple	HLTC

Additional Bill Information

Probable Fiscal Note: Yes
Preintroduction Required: N
Session Law Ch. Number: 365
DEADLINE
Category: General Bills
Transmittal Date: 03/01/2005
Return (with 2nd house amendments) Date: 04/06/2005

Section Effective Dates

Section (s)	Effective Date	Date Qualified
All Sections		Contingent upon certification by the director of public health and human services to the secretary of state that the moratorium on referrals by medical doctors to specialty hospitals provided for in section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 (42 U.S.C. 1395nn), has expired and not been continued.

SENATE BILL NO. 440

INTRODUCED BY D. HARRINGTON

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO LICENSE SPECIALTY HOSPITALS; PROVIDING A DEFINITION; PROVIDING REQUIREMENTS FOR LICENSURE; ENACTING A MORATORIUM ON LICENSURE OF SPECIALTY HOSPITALS UNTIL JUNE 1, 2007; AMENDING SECTION 50-5-101, MCA; AND PROVIDING A CONTINGENT EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 50-5-101, MCA, is amended to read:

"50-5-101. Definitions. As used in parts 1 through 3 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Accreditation association for ambulatory health care" means the organization nationally recognized by that name that surveys ambulatory surgical centers upon their requests and grants accreditation status to the ambulatory surgical centers that it finds meet its standards and requirements.

(3) "Activities of daily living" means tasks usually performed in the course of a normal day in a resident's life that include eating, walking, mobility, dressing, grooming, bathing, toileting, and transferring.

(4) "Adult day-care center" means a facility, freestanding or connected to another health care facility, that provides adults, on a regularly scheduled basis, with the care necessary to meet the needs of daily living but that does not provide overnight care.

(5) (a) "Adult foster care home" means a private home or other facility that offers, except as provided in 50-5-216, only light personal care or custodial care to four or fewer disabled adults or aged persons who are not related to the owner or manager of the home by blood, marriage, or adoption or who are not under the full guardianship of the owner or manager.

(b) As used in this subsection (5), the following definitions apply:

(i) "Aged person" means a person as defined by department rule as aged.

(ii) "Custodial care" means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available

to meet those basic needs.

(iii) "Disabled adult" means a person who is 18 years of age or older and who is defined by department rule as disabled.

(iv) (A) "Light personal care" means assisting the aged person or disabled adult in accomplishing such personal hygiene tasks as bathing, dressing, and hair grooming and supervision of prescriptive medicine administration.

(B) The term does not include the administration of prescriptive medications.

(6) "Affected person" means an applicant for a certificate of need, a health care facility located in the geographic area affected by the application, an agency that establishes rates for health care facilities, or a third-party payer who reimburses health care facilities in the area affected by the proposal.

(7) "Assisted living facility" means a congregate residential setting that provides or coordinates personal care, 24-hour supervision and assistance, both scheduled and unscheduled, and activities and health-related services.

(8) "Capital expenditure" means:

(a) an expenditure made by or on behalf of a health care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

(b) a lease, donation, or comparable arrangement that would be a capital expenditure if money or any other property of value had changed hands.

(9) "Certificate of need" means a written authorization by the department for a person to proceed with a proposal subject to 50-5-301.

(10) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, that creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

(11) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

(12) "College of American pathologists" means the organization nationally recognized by that name that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

(13) "Commission on accreditation of rehabilitation facilities" means the organization nationally recognized by that name that surveys rehabilitation facilities upon their requests and grants accreditation status to a rehabilitation facility that it finds meets its standards and requirements.

(14) "Comparative review" means a joint review of two or more certificate of need applications that are determined by the department to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the department's review of the other applications.

(15) "Congregate" means the provision of group services designed especially for elderly or disabled persons who require supportive services and housing.

(16) "Construction" means the physical erection of a health care facility and any stage of the physical erection, including groundbreaking, or remodeling, replacement, or renovation of an existing health care facility.

(17) "Council on accreditation" means the organization nationally recognized by that name that surveys behavioral treatment programs, chemical dependency treatment programs, residential treatment facilities, and mental health centers upon their requests and grants accreditation status to programs and facilities that it finds meet its standards and requirements.

(18) "Critical access hospital" means a facility that is located in a rural area, as defined in 42 U.S.C. 1395ww(d)(2)(D), and that has been designated by the department as a critical access hospital pursuant to 50-5-233.

(19) "Department" means the department of public health and human services provided for in 2-15-2201.

(20) "End-stage renal dialysis facility" means a facility that specializes in the treatment of kidney diseases and includes freestanding hemodialysis units.

(21) "Federal acts" means federal statutes for the construction of health care facilities.

(22) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

(23) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

(b) The term does not include offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors.

(24) "Home health agency" means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

(25) "Home infusion therapy agency" means a health care facility that provides home infusion therapy services.

(26) "Home infusion therapy services" means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's caregiver, or the patient's family member.

(27) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

(a) an inpatient hospice facility, which is a facility managed directly by a medicare-certified hospice that meets all medicare certification regulations for freestanding inpatient hospice facilities; and

(b) a residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

(28) (a) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals. ~~Services~~ Except as otherwise provided by law, services provided may or may not include obstetrical care, emergency care, or any other service allowed by state licensing authority. A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses. The term includes:

(i) hospitals specializing in providing health services for psychiatric, developmentally disabled, and tubercular patients; and

(ii) specialty hospitals.

(b) The term does not include critical access hospitals.

(29) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary--A" provides outpatient and inpatient care;

(b) an "infirmary--B" provides outpatient care only.

(30) (a) "Intermediate care facility for the developmentally disabled" means a facility or part of a facility that provides intermediate developmental disability care for two or more persons.

(b) The term does not include community homes for persons with developmental disabilities that are licensed under 53-20-305 or community homes for persons with severe disabilities that are licensed under 52-4-203.

(31) "Intermediate developmental disability care" means the provision of intermediate nursing care services, health-related services, and social services for persons with a developmental disability, as defined in 53-20-102, or for persons with related problems.

(32) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

(33) "Joint commission on accreditation of healthcare organizations" means the organization nationally recognized by that name that surveys health care facilities upon their requests and grants accreditation status to a health care facility that it finds meets its standards and requirements.

(34) "Licensed health care professional" means a licensed physician, physician assistant-certified, advanced practice registered nurse, or registered nurse who is practicing within the scope of the license issued by the department of labor and industry.

(35) (a) "Long-term care facility" means a facility or part of a facility that provides skilled nursing care, residential care, intermediate nursing care, or intermediate developmental disability care to a total of two or more individuals or that provides personal care.

(b) The term does not include community homes for persons with developmental disabilities licensed under 53-20-305; community homes for persons with severe disabilities, licensed under 52-4-203; youth care facilities, licensed under 52-2-622; hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or individuals who do not require institutional health care; or juvenile and adult correctional facilities operating under the authority of the department of corrections.

(36) "Medical assistance facility" means a facility that meets both of the following:

(a) provides inpatient care to ill or injured individuals before their transportation to a hospital or that provides inpatient medical care to individuals needing that care for a period of no longer than 96 hours unless

a longer period is required because transfer to a hospital is precluded because of inclement weather or emergency conditions. The department or its designee may, upon request, waive the 96-hour restriction retroactively and on a case-by-case basis if the individual's attending physician, physician assistant-certified, or nurse practitioner determines that the transfer is medically inappropriate and would jeopardize the health and safety of the individual.

(b) either is located in a county with fewer than six residents a square mile or is located more than 35 road miles from the nearest hospital.

(37) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients, the rehabilitation of mentally ill individuals, or any combination of these services.

(38) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

(39) "Offer" means the representation by a health care facility that it can provide specific health services.

(40) (a) "Outdoor behavioral program" means a program that provides treatment, rehabilitation, and prevention for behavioral problems that endanger the health, interpersonal relationships, or educational functions of a youth and that:

(i) serves either adjudicated or nonadjudicated youth;

(ii) charges a fee for its services; and

(iii) provides all or part of its services in the outdoors.

(b) "Outdoor behavioral program" does not include recreational programs such as boy scouts, girl scouts, 4-H clubs, or other similar organizations.

(41) "Outpatient center for primary care" means a facility that provides, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients and that is not an outpatient center for surgical services.

(42) "Outpatient center for surgical services" means a clinic, infirmary, or other institution or organization that is specifically designed and operated to provide surgical services to patients not requiring hospitalization and that may include recovery care beds.

(43) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

(44) "Person" means an individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

(45) "Personal care" means the provision of services and care for residents who need some assistance in performing the activities of daily living.

(46) "Practitioner" means an individual licensed by the department of labor and industry who has assessment, admission, and prescription authority.

(47) "Recovery care bed" means, except as provided in 50-5-235, a bed occupied for less than 24 hours by a patient recovering from surgery or other treatment.

(48) "Rehabilitation facility" means a facility that is operated for the primary purpose of assisting in the rehabilitation of disabled individuals by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

(49) "Resident" means an individual who is in a long-term care facility or in a residential care facility.

(50) "Residential care facility" means an adult day-care center, an adult foster care home, an assisted living facility, or a retirement home.

(51) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

(52) "Residential treatment facility" means a facility operated for the primary purpose of providing residential psychiatric care to individuals under 21 years of age.

(53) "Retirement home" means a building or buildings in which separate living accommodations are rented or leased to individuals who use those accommodations as their primary residence.

(54) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

(55) "Specialty hospital" means a specialty hospital as defined in [section 2].

~~(55)~~(56) "State health care facilities plan" means the plan prepared by the department to project the need for health care facilities within Montana and approved by the governor and a statewide health coordinating council appointed by the director of the department.

~~(56)~~(57) "Swing bed" means a bed approved pursuant to 42 U.S.C. 1395tt to be used to provide either acute care or extended skilled nursing care to a patient."

NEW SECTION. **Section 2. Department to license specialty hospitals -- standards -- definition -- moratorium.** (1) The department shall license specialty hospitals.

(2) A specialty hospital may not be licensed by the department unless that hospital provides:

(a) 24-hour emergency care that includes:

(i) one or more readily available emergency physicians to provide emergency care 24 hours a day, 365 days a year;

(ii) a roster of on-call medical staff; and

(iii) a written agreement with a full-service hospital that patients in the specialty hospital may be transferred to the full-service hospital on a priority basis; and

(b) medical services regardless of whether the payer of medical expenses incurred is an individual, a private payer, an insurance company, a government program payer, or another type of payer.

(3) As used in this section, "specialty hospital" means a specialty hospital as defined in 42 U.S.C. 1395nn.

(4) Notwithstanding the requirements of subsections (1) and (2), the department may not license a specialty hospital until July 1, 2007.

NEW SECTION. **Section 3. Codification instruction.** [Section 2] is intended to be codified as an integral part of Title 50, chapter 5, part 2, and the provisions of Title 50, chapter 5, part 2, apply to [section 2].

NEW SECTION. **Section 4. Contingent effective date.** [This act] is effective upon certification by the director of public health and human services to the secretary of state that the moratorium on referrals by medical doctors to specialty hospitals provided for in section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 (42 U.S.C. 1395nn), has expired and not been continued. The director shall certify the date of the expiration as soon as the expiration is effective and shall send a copy of the certification to the code commissioner.

- END -

MINUTES

MONTANA SENATE
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN BRENT R. CROMLEY**, on February 16, 2005 at 3:15 P.M., in Room 317-A Capitol.

ROLL CALL

Members Present:

Sen. Brent R. Cromley, Chairman (D)
Sen. John Cobb (R)
Sen. John Esp (R)
Sen. Duane Grimes (R)
Sen. Lynda Moss (D)
Sen. Jerry O'Neil (R)
Sen. Trudi Schmidt (D)
Sen. Dan Weinberg (D)
Sen. Carol Williams (D)

Members Excused: None.

Members Absent: None.

Staff Present: David Niss, Legislative Branch
Rita Tenneson, Committee Secretary

Please Note. These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing & Date Posted:	SB 440, 2/14/2005; SB 446, 2/14/2005
Executive Action:	SB 324; SB 446; SB 317; SB 281

HEARING ON SB 440

Opening Statement by Sponsor:

SEN. DAN HARRINGTON (D), SD 38, opened the hearing on **SB 440,** Require licensure of specialty hospitals.

SEN. HARRINGTON said the bill came from a situation in Butte where a number of physicians began exploring a new for-profit hospital for the community. It was designed to do expensive surgical procedures for people with insurance coverage. He said St. James Community Hospital and Health Care is important to all the people of Butte's community, and the prospect of another hospital in Butte raised concerns for many people. The issue of specialty hospitals is pending in Congress and should be resolved there. In the event it isn't, this bill gives the Montana Legislature flexibility in these situations.

Proponents' Testimony:

John Flink, Montana Hospital Association rose in support of **SB 440,** read his testimony and included additional information on limited-service providers.

EXHIBIT(phs38a01)
EXHIBIT(phs38a02)

{Tape: 1; Side: A; Approx. Time Counter: 0 - 9.5}

James Kiser, Hospital Administrator, St. James Hospital and Health Care, Butte, MT, asked to have the moratorium extended for 18 months in the event the federal government does not extend it for limited services hospitals. Montana is among five states with the most uninsured people. The bill is not about competition, it is about protecting uninsured within the State. Many hospital services are not self-sustaining, so hospitals cross-subsidize services to cover these.

{Tape: 1; Side: A; Approx. Time Counter: 9.5 - 14.1}

John Solheim, CEO, St. Peters Hospital, Helena, said the issue needs to be resolved at the federal level but, if they don't act, he wants the Legislature, in 2007, to have the flexibility to act on it.

Mike Foster, representing St. James Hospital, Butte; St. Vincent, Billings; Holy Rosary, Miles City; Wibaux Memorial in Harlowton, said this is a very important issue for these hospitals, especially St. James in Butte. A lot of studies have been done

regarding specialty hospitals and Congress wasn't sure how to address this new element in the economic structure of health care. Congress didn't feel they had enough information so they passed a moratorium in the Medicare Modernization Act saying no new specialty hospitals can be built in America until June of 2005. A moratorium extension is being proposed by MedPAC. If that occurs, this adds six months so the Legislature can look at what Congress did. This bill gives Montana participation in a finding a solution.

{Tape: 1; Side: A; Approx. Time Counter: 14.1 - 20}

Mr. Foster presented a letter from **Dr. Nick Wolter, Chief Executive Officer, Deaconess Billings Clinic**, rose in support. His letter refers to some of the recommendations the MedPAC report on specialty hospitals is going to make to Congress.

EXHIBIT(phs38a03)

Opponents' Testimony:

Pat Melby, Montana Medical Association, and the Association of Physicians Practicing Medicine in Montana, opposed the bill. They feel it is a nation-wide turf battle between hospitals, specialty hospitals and physicians. Hospitals have asked for legislation banning creation of any facility that focuses strictly on cardiac care, orthopedic services, or cancer treatment; legislation prohibiting physicians from having a financial ownership in specialty hospitals; resisted appeal of certificate of need; legislation requiring hospitals, long-term care facilities; and primary clinics to provide information to state departments of health on financial liability, sustainability and potential impact on health care access of those kinds of facilities; legislative studies on niche providers, including specialty hospitals; and legislation requiring specialty hospitals to provide emergency services and accept Medicare and Medicare uninsured patients. This bill adopts the emergency services portion. Specialty care facilities already accept Medicare and Medicare uninsured patients. He said adopting this bill would give Montana a disadvantage in competing with medical centers in surrounding states. He suggested an amendment that, if the bill is passed, it sunsets in 2007.

{Tape: 1; Side: A; Approx. Time Counter: 20 - 25.7}

LaDawn Muir, Hospital In-Patient supervisor, Central Montana Surgical Hospital, said they are a specialty hospital, with an ER. They have transfer agreements with nonprofit hospitals under

the Medicare-Medicaid providers law and Corporate Certificate of Public Advantages. Their hospital provides more medical choices. As a profit organization, they pay taxes to the community. Not being able to license until 2007 stifles competition and business opportunities for both the community and the State.

{Tape: 1; Side: A; Approx. Time Counter: 25.7 - 28.2}

Informational Testimony: None.

Questions from Committee Members and Responses:

SEN. ESP asked if there was a federal definition of specialty hospitals. **Mr. Foster** said the Medicare Modernization Act defines specialty hospitals and that definition is written up in **SB 440.**

SEN. CROMLEY asked about a grandfather clause pertaining to the two specialty hospitals already in existence. **Mr. Flink** told him the federal moratorium includes the grandfather clause covering existing hospitals as of November 18th, 2003. He asked **Mr. Niss** to clarify that in an amendment to continue to grandfather those facilities if the federal moratorium expires and the Montana moratorium took affect.

SEN. CROMLEY asked **Mrs. Muir** if their license was the same as general hospitals. She answered yes. **SEN. CROMLEY** asked if they could continue if the moratorium failed. **Mrs. Muir** had concerns about the grandfather clause as it wasn't specific in the bill.

SEN. ESP asked **Mary Dalton** if the two specialty hospitals would qualify for licensure based on the criteria in the proposed definition. **Mrs. Dalton** answered that since they read the bill in relationship with the moratorium, they would be licensed. **SEN. ESP** asked if they were required to do all the things in the definition as general hospitals. **Mrs. Dalton** told him it was her understanding that hospitals do not have to provide 24-hour emergency care as such as general hospitals.

SEN. WEINBERG asked **Mrs. Dalton** if testimony regarding whether or not specialty hospitals take Medicaid patients was true. **Mrs. Dalton** answered she didn't know, but would find out before the Committee took executive action. **SEN. WEINBERG** requested her to get information on the ratio of private pay for medicare patients, as well.

SEN. CROMLEY asked **Mr. Flink** if specialty hospitals were required to provide 24-hour emergency care. **Mr. Flink** answered that, in

general terms of definition, "specialty hospitals" means hospitals primarily or exclusively engaged in care or treatment of one of the following categories; patients with a cardiac condition, patients with an orthopedic condition, patients receiving a surgical procedure, any other specialized categories services the secretary of Health and Human Services designates as being consistent with the purpose of permitting physician ownership and investment in a hospital under this section.

Closing by Sponsor:

SEN. HARRINGTON said an amendment to grandfather in the existing specialty hospitals was fine with him. Thirty cents out of every dollar we pay for health care goes for people who don't have health care. This is one of the reasons he felt strongly we should protect non-specialty hospitals.

HEARING ON SB 446

Opening Statement by Sponsor:

SEN. TRUDI SCHMIDT (D), SD 11, opened the hearing on **SB 446**, Providing for formation and operation of family councils in nursing homes.

SEN. SCHMIDT said this is not a one-area problem, she had done considerable research before she agreed to carry the bill. She found people felt it important to be comfortable with the care of their parents or loved ones, when in nursing facilities.

Proponents' Testimony:

Kathy Doughty, Montana Nurses' Association, rose in support of the bill. She presented testimony from a daughter of a nursing home resident in Dillon.

EXHIBIT(phs38a04)

Alana Kietzmen, Montana Long Term Care Ombudsman, said she supports the bill. Some residents do not have family members close-by, therefore the councils can assist them with problems. The councils advocate and give support to families. She handed the committee information on family councils and the ombudsman program.

EXHIBIT(phs38a05)
EXHIBIT(phs38a06)

SENATE PUBLIC HEALTH, WELFARE & SAFETY
EXHIBIT NO. 1
DATE: 2-16-05
BILL NO. SB 440

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Facts About SB 440

Officers

Chairman
Kent Burgess
Billings

Chairman-Elect
Scott Duke
Glendive

Immediate Past Chairman
John Bartos
Hamilton

Treasurer
Michelle Hood
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James E. Ahrens
Helena

Trustees

Velinda Stevens
Kalispell

Jay Pottenger
Fort Benton

Larry Putnam
Malta

James Kiser
Butte

Tim Russell
Columbus

Nancy Hansen
Chinook

Kerry Beasley
Libby

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Wolf Point

Shane Roberts
Ronan

Nicholas J. Wolter, MD
Billings

Kelley Evans
Red Lodge

Background

The delivery of health care is changing rapidly. This is fueled by many factors, including the development of new technology, new treatment techniques and new settings in which to deliver medical treatment.

One trend in recent years has been the development of facilities that focus on specific conditions or procedures – e.g. heart, orthopedic and surgical services. The American Hospital Association estimates that there are over 100 limited-service hospitals currently operating – nearly triple the number in 1997. Most of these facilities are either partially or fully-owned by physicians. Two operate in Montana – in Great Falls and Kalispell.

Their development raises a number of difficult public policy questions:

- **Should physicians be allowed to refer patients to facilities that they own?** The financial incentives created by physician ownership can lead to higher referral rates for services and potentially unnecessary utilization – both of which drive up overall health care costs.

- **How do these facilities affect access to care in communities with not-for-profit, community-based hospitals?** The owners of these facilities have the ability to shift the well-reimbursed services and patients to their own facility. This practice can undermine the financial stability of the local community-based hospital, which relies on these patients to offset losses from essential community services and care for low-income populations. In some cases, full-service hospitals may not be able to maintain services, thus reducing access to care for the whole community and surrounding area.

- **How does the quality of care compare in specialty hospitals versus general acute care facilities?** The Medicare Payment Advisory Commission (MedPAC) – an independent commission that advises Congress on Medicare policy – has called for "a better understanding of the quality of care provided in alternative settings, including safety, regulatory oversight and clinical considerations."

- **What impact does the development of a specialty hospital have on the overall cost of health care?** Specialty hospitals usually duplicate the services already provided at the local full-service hospital. Duplication of these services adds to the overall cost of health care.

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Current Law

Under a 1989 federal law, physicians cannot refer Medicare patients to a clinical laboratory in which the physician or an immediate family member has a financial interest. In 1993, this law was extended to cover referrals for additional health care services including radiology and inpatient and outpatient hospital services.

However, this law contains a number of exceptions that allow physicians to continue to invest in facilities to which they refer patients. As a result, the number of specialty hospitals has continued to grow dramatically.

The Medicare Modernization Act of 2003 – the bill that established the Medicare prescription drug benefit – addressed this issue in two ways:

- Congress imposed a moratorium on the development of new specialty hospitals until June 2005.
- During this moratorium, Congress commissioned two studies to examine the public policy issues raised by specialty hospitals. Before January 2007, Congress is expected to use these studies to further refine federal policy.

While these studies may be completed prior to expiration of the moratorium, Congress is not expected to act on legislation until later this year – well after the moratorium ends.

For this reason, MedPAC has recommended extending the federal moratorium until January 2007. MedPAC also has recommended modifying the Medicare reimbursement structure to level the playing field for all hospitals.

How does SB 440 Fit Into This Picture?

SB 440 provides a moratorium on limited service hospitals through June 30, 2007, which allows the Montana Legislature, if necessary, an opportunity to discuss these public policy issues during the 2007 session.

In the meantime, Congress will examine the two studies they commissioned in 2003 and explore public policy options for addressing this important issue.

SB 440 gives the Montana Legislature flexibility. If Congress does not act to resolve this issue between now and June 30, 2007, the Montana Legislature will have an opportunity to do so during the 2007 session.

SENATE PUBLIC HEALTH, WELFARE & SAFETY
EXHIBIT NO. 2
DATE 2-16-05
BILL NO. SB 440

American Hospital Association

TRENDWATCH

Impact of Limited-service Providers on Communities and Full-service Hospitals — *September 2004, Vol. 6, No. 2*

Limited-service providers, often referred to as "niche" providers, are a growing presence in the health care field. These providers focus on specific conditions or procedures (e.g., heart, orthopedic, and surgical services) and include single-specialty and multi-specialty hospitals, ambulatory surgical centers (ASCs), and diagnostic testing facilities. They are more common in states without Certificate of Need (CON) regulations, and most are either partially or fully-owned by physicians.

The AHA estimates that there are well over 100 limited-service hospitals currently operating—nearly triple the number from 1997—and that approximately 30 more currently are under development.[1] In addition, 3,735 Medicare-certified ASCs currently are open, growing at a rate of 6 percent per year.[2]

The impact that these facilities have on patients and the broader health care delivery system is beginning to be better understood. Physicians' ability to refer to facilities in which they are owners has the potential to place the medical interests of the patient at odds with the financial interests of the physician. Past research in other practice settings indicates that the financial incentives created by physician ownership can lead to higher referral rates for services and potentially unnecessary utilization.[3]

The impact on broader access to care for the community is another concern. As owners of the facilities to which they refer, physicians have both the ability and the financial incentives to shift the well-reimbursed services and patients to their own facility. This practice can drain essential resources from full-service hospitals that rely on these patients to cross-subsidize money-losing, but essential community services (e.g., burn, emergency and trauma care) and care for low-income populations.

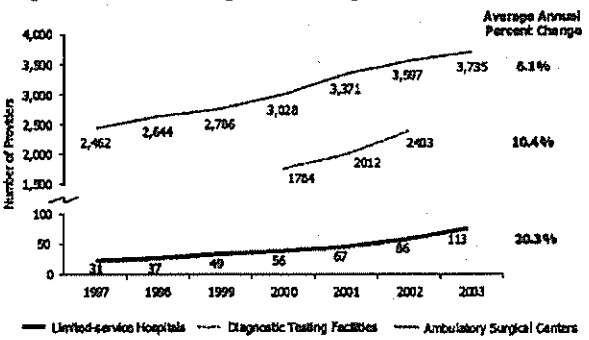
Last year, Congress recognized these concerns and placed an 18-month moratorium on physician self-referral of Medicare and Medicaid patients to new limited-service hospitals while the Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) study the issue.

New medical technology and the associated shift of care to outpatient settings have contributed to the growth of limited-service providers. Widespread physician access to capital, the prospect of more operational control and productivity, and high profit margins have made limited-service providers attractive ventures for physicians.

This issue of TrendWatch highlights the trends and implications of the growth of limited-service providers.

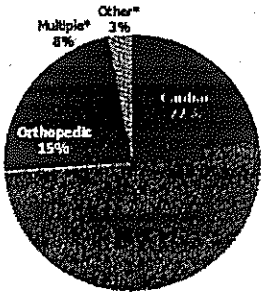
The number of limited-service providers is growing rapidly.

Chart 1: Number of Limited-service Hospitals, Ambulatory Surgical Centers, and Diagnostic Testing Facilities, 1997-2003



Newer limited-service hospitals are focusing on cardiac, orthopedic, and surgical care...

Chart 2: Percentage of Limited-service Hospitals by Specialty, 2004

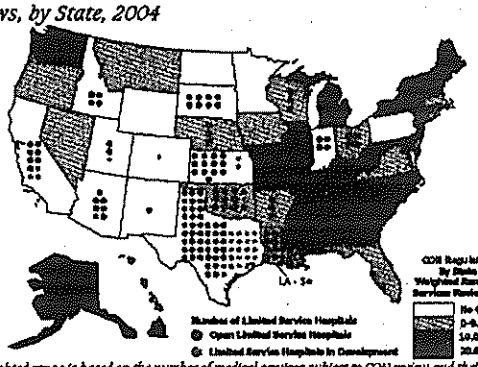


n = 170 Limited-service Hospitals open and in development

Note: Consistent with the Medicare Modernization Act, long-term acute care, cancer, psychiatric, children's, and rehabilitation hospitals are not included in the definition of limited-service hospitals.
**Multiple includes a combination of orthopedic, surgical and/or cardiac. Other includes limited-service hospitals that could not be identified with respect to specialty area.*

...with the greatest proliferation in states having no CON regulations.

Chart 3: Number of Limited-service Hospitals Relative to CON Laws, by State, 2004



**Weighted range is based on the number of medical services subject to CON review and their importance; facilities in development reported by state hospital associations, data may be incomplete*

The Lewin Group

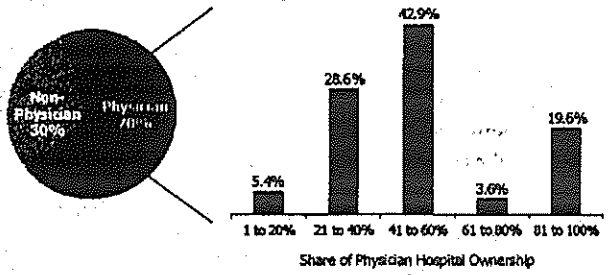
Physician ownership of limited-service providers raises concerns about self-referral...

Seventy percent of limited-service hospitals currently operating or under development have some level of physician ownership. The share of physician ownership averages just over 50 percent.[1] Physicians also have ownership stakes in approximately 83 percent of ASCs.[2]

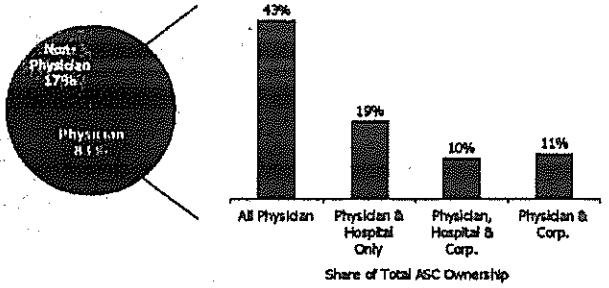
The ability of physicians to refer to facilities in which they have an ownership interest can create an inherent conflict between the clinical needs of the patient and the financial interests of the physician. The opportunity for financial gains beyond professional fees, including a share in facility profits and an equity interest, can create incentives to increase and direct patient referrals based on economic rather than clinical criteria.[3]

Physician ownership of limited-service providers is substantial...

Chart 4: Physician Ownership of Limited-service Hospitals, 2003



Physician Ownership of ASCs, 2004



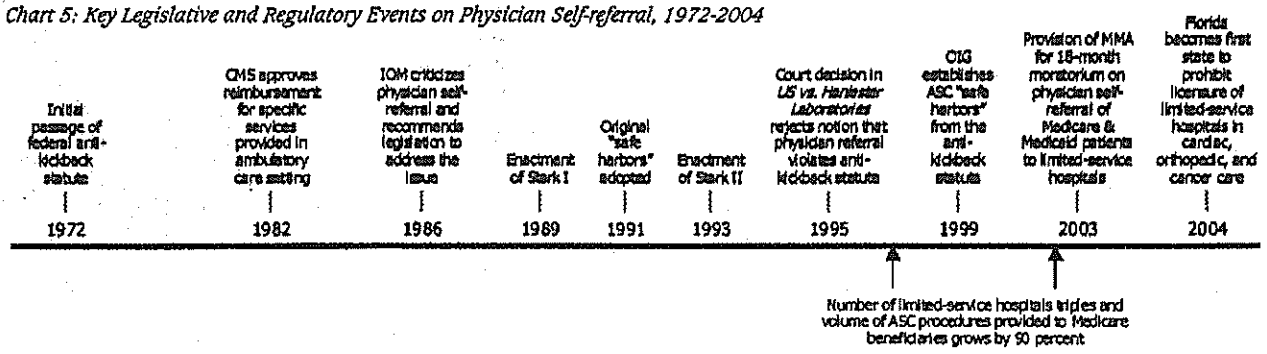
In 1972, Congress passed the federal anti-kickback statute to address the issue of improper financial inducements. The statute prohibits entities from offering or receiving remuneration tied to the referral of Medicare and Medicaid patients. In 1991 and 1999, the Office of Inspector General (OIG) promulgated exceptions to the federal anti-kickback statute, which, in addition to statutory exceptions, are collectively known as "safe harbors." These rules protect certain types of activities (e.g., investment in certain types of Medicare-certified ASCs, joint ventures, and group practices) from violation under the federal anti-kickback statute, subject to certain requirements. Various interpretations of these laws have facilitated physician investment in limited-service providers.[4]

In 1989, Congress enacted the Ethics in Patient Referrals Act to limit physician self-referral. Under the original statute (commonly referred to as Stark I), a physician cannot refer Medicare patients to a clinical laboratory in which the physician, or an immediate family member, has a financial interest, subject to certain exceptions. In 1993, the law was extended (Stark II) to cover referrals for additional "designated health services,"[5] including radiology and inpatient and outpatient hospital services, among others.[6]

The Stark law contains a number of exceptions. In particular, the "whole hospital" exception permits self-referrals by physicians when they have ownership in the whole hospital, as opposed to a subdivision of a hospital. The legislative intent of the exception was to allow for ownership in general hospitals that offer a full spectrum of health care services, where a single referral would produce little personal economic gain. Since limited-service hospitals are much smaller—often closer in size and the scope of services to a hospital department—the potential for personal financial gain to influence physician referral has raised concerns.[7] This exception allows physician self-referral to any inpatient or outpatient service offered by the "whole hospital" including diagnostic services, such as lab and imaging.

...despite various efforts to regulate physician self-referral.

Chart 5: Key Legislative and Regulatory Events on Physician Self-referral, 1972-2004


Initial passage of federal anti-kickback statute
1972
CMS approves reimbursement for specific services provided in ambulatory care setting
1982
IOM criticizes physician self-referral and recommends legislation to address the issue
1986
Enactment of Stark I
1989
Original "safe harbors" adopted
1991
Enactment of Stark II
1993
Court decision in US vs. Hanlester Laboratories rejects notion that physician referral violates anti-kickback statute
1995
OIG establishes ASC "safe harbors" from the anti-kickback statute
1999
Provision of MMA for 18-month moratorium on physician self-referral of Medicare & Medicaid patients to limited-service hospitals
2003
Florida becomes first state to prohibit licensure of limited-service hospitals in cardiac, orthopedic, and cancer care
2004
Number of limited-service hospitals triples and volume of ASC procedures provided to Medicare beneficiaries grows by 90 percent

...and utilization of health care services.

Case studies document a discernible shift in volume when referring physicians acquire a personal financial interest in a limited-service provider. For example, a study in Louisiana found that physician investors in an ASC reduced referrals to the full-service hospital by approximately 50 percent, while non-investor surgical volume remained relatively constant.[1] Similarly, a study in South Dakota found that the number of cases at the full-service hospital fell by 77 percent upon the opening of an ASC.[2]

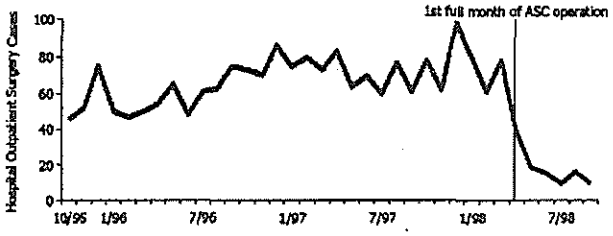
Physician self-referral also is linked to higher use of services. In 1989, the OIG found that patients of physician-owned clinical laboratories received 45 percent more laboratory services than Medicare patients in general.[3] Additionally, a 1994 GAO analysis of referral patterns of investor and non-investor physicians in Florida found physician owners ordered 54 percent more MRI scans, 27 percent more CT scans, 37 percent more nuclear medicine scans, 27 percent more echocardiograms, 22 percent more ultrasound services, and 22 percent more complex X-rays.[4]

Hospital and health plan leaders have expressed concern about the overall impact of physician-owned limited-service providers on access to care, utilization and costs. Financial incentives that promote greater service use may put patients at risk and drive up health care costs. Costs to the community may also increase due to the creation of duplicative capacity. The actions full-service hospitals must take in response to shifts in capacity and utilization may affect costs and access as well. These steps may include recruiting additional physicians to maintain emergency access to affected services, budget cuts and service reductions in other areas, or, when possible, negotiating higher rates with private payers for other services. In some cases, full-service hospitals may not be able to maintain services in affected areas, reducing access to care for the broader community.

Questions have been raised about the quality of care provided in certain limited-service settings. For example, in a recent report to Congress, MedPAC examined the growth of ASCs and the high rate of utilization of services at these facilities. Noting that regulation of ASCs is less stringent than that of hospital outpatient departments, the report called for "a better understanding of the quality of care provided in alternative settings, including safety, regulatory oversight, and clinical considerations."[5]

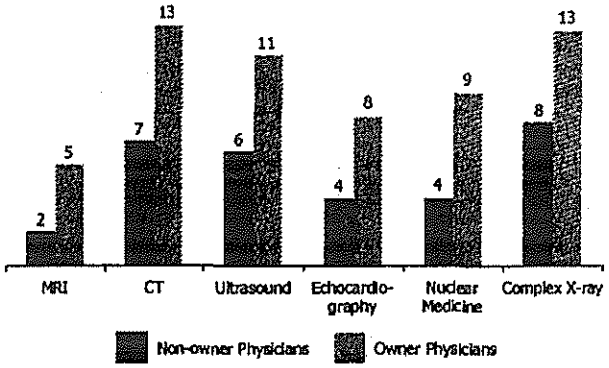
Physician ownership influences where physicians direct referrals...

Chart 6: Orthopedic Surgeries Performed by Physician Investors at a Full-service Hospital System Before and After ASC Opening, October 1995 – September 1998



...and the amount of care they provide.

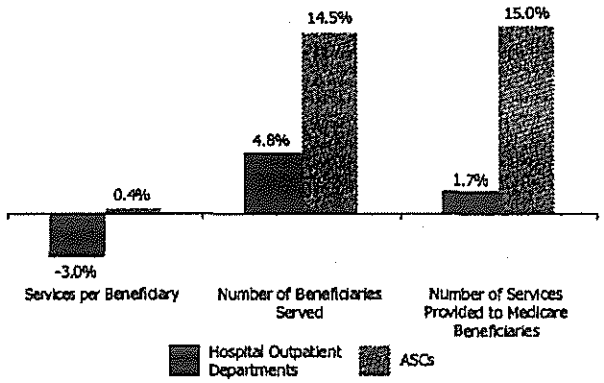
Chart 7: Number of Imaging Services Ordered per Physician, Owner vs Non-owner, 1990



NOTE: Information from Florida Health Care Cost Containment Board and Florida BCBS; analysis includes 16,157 physicians.

Medicare data reflects the impact of ASC growth on service use and setting of care.

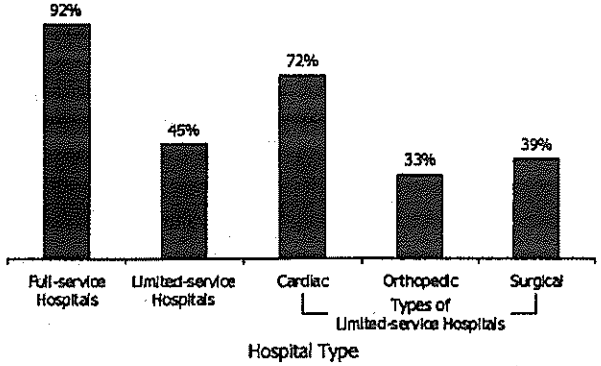
Chart 8: Average Annual Percent Change in Medicare Outpatient Surgical Volume, ASC vs. Hospital, 1998 – 2002



Limited-service hospitals appear to focus on the most profitable services and patients...

Limited-service hospitals typically do not have emergency departments...

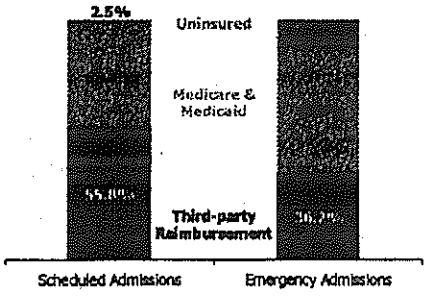
Chart 9: Percentage of Full-service and Limited-service Hospitals with Emergency Departments



Note: Data for general hospitals are from AHA's Annual Survey (2001). Specialty hospital data are from GAO's specialty hospital survey (2003), GAO's contacts with hospital administrators, and the CMS POS file (2003).

...affording them more control over their payer mix.

Chart 10: Percentage of Cases by Payer: Hospitals in Houston, TX, 2002



Physician owners have both the ability and financial incentives to direct patients to or away from the facilities in which they have an ownership interest. As such, limited-service hospitals tend to: 1) specialize in well-reimbursed services; 2) serve fewer high-acuity patients; and 3) serve fewer low-income and uninsured patients. Such practices can produce high returns for physician investors but place full-service hospitals at a disadvantage as they depend on a balance of services and patients to support the broader health needs of the community.

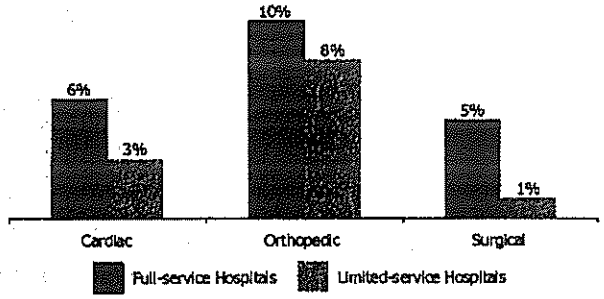
Payment relative to cost varies considerably depending on the type of service, the payer and the acuity level of patients. Heart, orthopedic and general surgical cases are among the most highly reimbursed relative to cost, and limited-service providers typically focus on these high volume, high margin services.[1]

Medicare and Medicaid pay less than private insurers for the same services, and providers receive little or no reimbursement for services to indigent patients. Medicare and many other payers reimburse a flat average rate for a specific case-type, regardless of patient acuity, with exceptions made for extremely high cost patients through outlier payments.[2]

Most limited-service hospitals do not have emergency departments (EDs),[3] affording them more control over their payer mix and patient acuity level. Unlike full-service hospitals, limited-service hospitals without EDs do not maintain costly standby capacity and do not have the obligation under the Emergency Medical Treatment and Labor Act (EMTALA) to screen and stabilize all patients, regardless of their ability to pay. Because emergency admissions are generally more acute and less stable than those that are elective, limited-service hospitals typically serve fewer high acuity patients relative to full-service hospitals.

These facilities deliver a lesser proportion of their care to low-income patients...

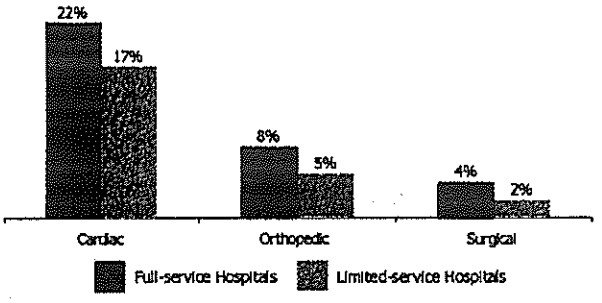
Chart 11: Medicaid Patients as a Percent of Total Patients, Full-service Hospitals vs. Limited-service Hospitals, 2000



Note: Analysis based on HCUP data from six states. Compared limited-service hospitals to full-service hospitals in the same market area.

...and serve a lower acuity patient population relative to full-service hospitals.

Chart 12: Severely Ill Patients as a Percent of Total Patients, Full-service Hospitals vs. Limited-service Hospitals, 2000



Note: Analysis based on HCUP data from six states. Compared limited-service hospitals to full-service hospitals in the same market area.

...limiting the ability of full-service hospitals to support the range of services essential to the community.

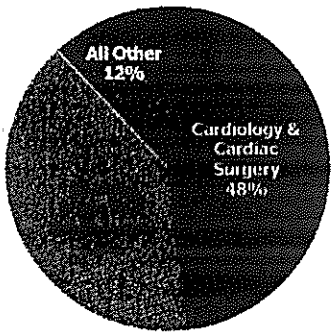
The rapid growth of limited-service providers raises concerns about their impact on care delivery in the community. As physicians move their practices to limited-service providers, they leave full-service hospitals less able to maintain the broad range of services vital to meeting community health needs.

The current payment system does not explicitly fund standby capacity for emergency, trauma and burn service categories, nor does it fully reimburse hospitals for care provided to Medicaid and uninsured patients. Full-service hospitals rely on cross-subsidies from some well-reimbursed services to be able to provide other under-reimbursed but essential community services.

These effects are illustrated in one midwest community after a physician-owned limited-service hospital opened in 1997. Three of four neurosurgeons—physician investors in the new facility—subsequently resigned from the full-service community hospital, significantly reducing neurosurgeon coverage in the community's only emergency department. To compensate for the gaps in emergency and trauma care, the hospital shifted to temporary staff coverage; however, this solution has proven difficult to maintain. In addition to the impact on the community at large, the hospital saw surgical volume drop across neurosurgery and other affected specialties (e.g. orthopedics). Operating room efficiency declined when elective cases were lost, but capacity for emergency cases had to be maintained.[1]

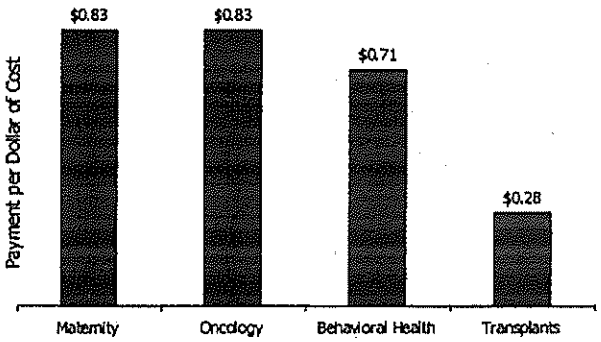
When physician-owners focus on well-paying services...

Chart 13: Percent of Net Income by Service in a Community Hospital System in the Southwest Region, 2003



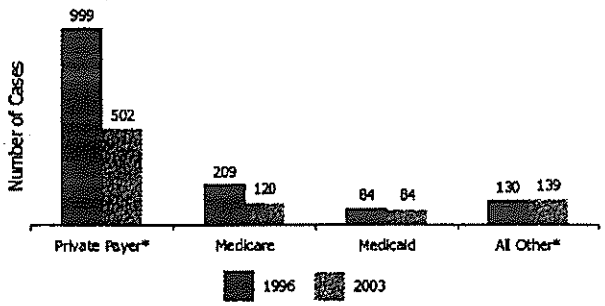
...full-service hospitals are less able to support essential, but money-losing care...

Chart 14: Payment per Dollar of Cost for Essential Services, a Community Hospital System in Southwest Region, 2003



...as they lose higher paying patients to limited-service hospitals.

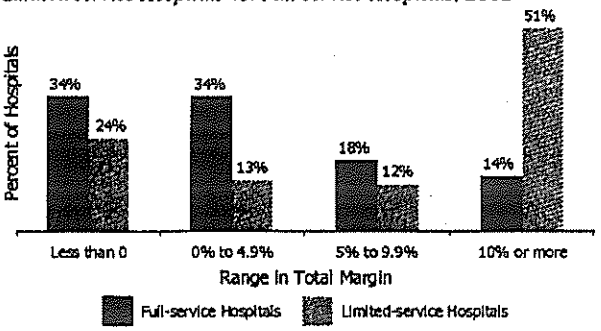
Chart 15: Changes in Orthopedic Cases, a Midwest Community Hospital After Surgical Hospital Opened in 1997, 1996-2003



"Private payer" includes BCBS, workers compensation, commercial insurance, managed contract care, and other insurance. "All other" includes CHAMPUS, self-pay and public health insurance.

These practices contribute to limited-service hospitals' higher profitability.

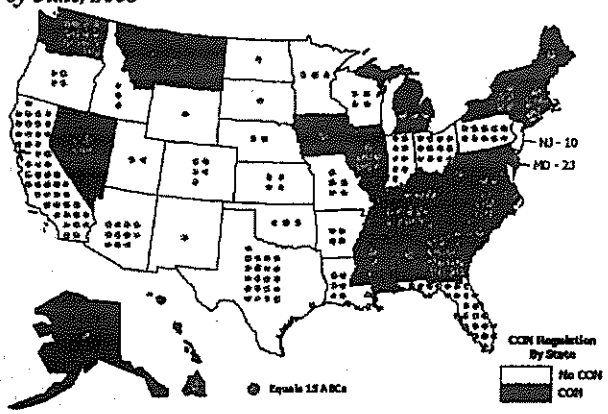
Chart 16: Percent of Hospitals by Range in Total Margin, Limited-service Hospitals vs. Full-service Hospitals, 2002



Federal and state governments are attempting to address concerns with limited-service provider growth and referral.

ASCs are primarily located in states with minimal or no CON regulation.

Chart 17: Number of ASCs Relative to CON Laws Governing ASCs, by State, 2003



States are grappling with the challenge of further regulating limited-service providers.

Chart 18: Examples of State Legislative Activity, 2003

Types of Rules	State Examples
Emergency Services	**AZ, CA & LA:** *Proposed legislation* to establish standards for emergency services at limited-service hospitals and ASCs (e.g., immediate availability of emergency physician, transfer agreements) or prohibited licensure unless hospitals maintain an ED. **WA & NE:** *Vetoed legislation* to require limited-service hospitals to provide 24/7 ED services. **IL:** *Enacted Hospital Licensing Act* to require all hospitals to have emergency department in order to receive licensure.
Certificate of Need Regulations	**AL:** *Enacted legislation* to increase thresholds for certain CON exemptions. **IL:** Legislation extended CON sunset to July 1, 2008. **MA:** *Enacted legislation* to require all facilities to apply for state review to add new services or make capital improvements.
Types of Procedures	**CA:** *Vetoed legislation* to prohibit licensure for hospitals with limited inpatient services (e.g., surgical procedures). **FL:** *Enacted legislation* to prohibit licensure of limited-service hospitals and facilities with 65 percent of discharges in cardiac, orthopedic, and cancer care. **NJ:** *Enacted legislation* to levy 3.5 percent tax on certain physician-owned ASCs. **GA:** *Proposed legislation* to impose 6 percent provider fee on ASC, laboratory, or diagnostic or imaging services.
Safety Net	**NM:** *Proposed legislation* to provide emergency services to non-paying patients and low-income reimbursed patients in the same proportion as patients treated in acute-care general hospitals. **OK:** *Enacted legislation* to impose fee on limited-service hospitals who have not earned at least 30 percent of annual revenue from Medicare, Medicaid and uncompensated care.
Physician Ownership (Stark-like)	**CA, CO, IN, LA, MA, OH & KY:** *Proposed legislation* to prohibit physicians with ownership interest in limited-service provider facilities from making patient referrals to those facilities. **MI:** *Enacted law* that included federal anti-referral law (Stark) under unprofessional conduct for health professions. **SC:** *Implemented regulation* to extend the federal prohibition on self-referral to all patients. **WA & MO:** *Proposed* or *enacted* temporary ban on physician self-referral to new limited-service hospitals.

Various types of laws have been enacted to address issues of physician self-referral, capacity control and adequacy of health care delivery. Some of these endeavors, however, have been unsuccessful. Loopholes in some statutes, such as the "whole hospital" exception, have undermined many of the original goals.

Several forms of regulatory oversight focus on the supply of health care. For example, Certificate of Need (CON) regulations require that a permit be issued by a state agency before a health care facility may construct or expand, offer a new service or purchase equipment exceeding a certain cost. The purpose of CON laws was to prevent duplication of resources and limit excess bed capacity and services in communities. Congress required all states to enact CON laws in 1974, but later repealed that requirement and passed the responsibility onto states. Currently, 36 states and the District of Columbia have CON requirements, and most limited-service providers are located in states with no CON requirements, such as California and Texas.[1]

Federal and state governments have been proactive in addressing concerns around the growth and oversight of limited-service providers. When Congress passed the Medicare Modernization Act (MMA) in 2003, they placed an 18-month moratorium on physician self-referral under Medicare for new limited-service hospitals while MedPAC and the Department of Health and Human Services (HHS) study the issue. The law specifically covers cardiac, orthopedic and surgical hospitals but can be expanded at the discretion of HHS. Hospitals already in operation or under development as of November 18, 2003 are exempt. A bipartisan group of House members currently is pushing for further legislative action on limited-service providers, while a few states, including Washington and Missouri, have enacted or plan to enact a regulation banning physician self-referral to new limited-service hospitals, similar to the federal moratorium.[2]

At the state level, South Carolina has enacted more stringent Stark-like legislation by extending the federal prohibition on self-referral to all patients. Additionally, Illinois recently enacted legislation to require that all hospitals include a full-service ED, thereby making them subject to EMTALA, and Arizona proposed legislation to establish transfer agreements between full-service hospitals and limited-service providers.[3]

Limited-service providers raise broader issues about the health care system.

Limited-service providers have potentially significant effects on the health care system and on communities served. Subjects of greatest concern include the appropriateness of physician self-referrals, the role of competition in health care, and regulatory approaches that create unintended competitive advantages or disadvantages.

Proponents of physician-owned limited-service providers argue that competition from such facilities will lead to improved quality, service and efficiency. Others cite data suggesting that physician-owners and other investors can profit from such tactics as:

- Not taking on the commonly accepted roles and associated costs of a full-service hospital;
- Selecting a narrow range of service offerings; and,
- Using the physician-owners' ability to direct referrals to steer patients either to the facility in which they have a financial interest (self-referral) or to a full-service competitor.

Full-service hospitals are concerned that they will become unable to perform safety-net roles essential to their communities as limited-service facilities compete for patients. These safety-net roles include:

- Serving as a key access point for care for the nearly 45 million Americans without health care coverage, an expectation guaranteed by federal EMTALA requirements for hospitals having emergency departments.
- Providing standby capacity for routine emergencies, disaster readiness, trauma, burn units, and/or other essential community services.
- Delivering a wide array of services to a broad range of payers and patients of varying acuity levels.

This issue adds to the broader public policy debate about how best to provide affordable and accessible health care for all Americans.

Quotes from the Field

"Central to keeping the balance of services and community access is the issue of cross-subsidization. Full-service hospitals must rely on the ability to use revenues from the more highly reimbursed services to subsidize and sustain low- or no- profit services that are critically needed."

William Petasnick, President and Chief Executive Officer of Froedtert Hospital and Community Health System, Milwaukee, WI

"There are a lot of issues raised about the impact niche hospitals have on big hospitals — which are our health care safety net. There are also some questions about what type of disclosure a doctor needs to give a patient if that doctor owns part of the hospital." — Amanda Engler, spokeswoman for the Texas Hospital Association

"How can a doctor who is part owner of a for-profit [specialty provider] be expected to fulfill his or her duties towards his or her co-workers and in the same instance fulfill the duties towards the principal who is a not for profit hospital? This does not imply ill-will on the part of the doctor, it simply faces fundamental medical issues such as at which institution does the doctor place his or her patients....? We have often stated that an agent cannot serve two masters. This rule applies to medical professionals as well." — South Dakota Supreme Court ruling on an antitrust case involving Avera Health System and the Orthopedic Surgery Specialists

Endnotes:

Page 1:
[1] The Lewin Group analysis of AHA state survey data, 2004
[2] CMS Office of the Actuary, 2004
[3] Hillman, BJ, Joseph, CA, Mabry, MR, Sunshine, JH, Noether, M., "Frequency and costs of diagnostic imaging in office practice—a comparison of self-referring and radiologist-referring physicians," *New England Journal of Medicine*, vol. 323, 1990; Mitchell, JM, Scott, E., "Physician ownership of physical therapy services: effects on charges, utilization, profits, and service characteristics," *JAMA*, vol. 268, 1992

Page 2:
[1] United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003
[2] American Association of Ambulatory Surgery Centers (AAASC) ASC Ownership Survey, February 2004
[3] Unland, James J, "Can Community Hospitals Survive Without Large Scale Health Reform?," *Journal of Health Care Finance*, Spring 2004
[4] Saner, RJ, Spindel, MP, and Fitzgerald, M, *New and Clarified Anti-Kickback Safe Harbors Issued*, Powers Pyles Sutter & Verville P.C., http://www.ppsv.com/issues/kickback.htm
[5] Designated health care services include: clinical laboratory; radiology; durable medical equipment; physical therapy; occupational therapy; radiation therapy services & supplies; parenteral & enteral nutrients, equipment & supplies; outpatient prescription drugs; prosthetics; home health services; and inpatient & outpatient hospital services
[6] Satiani, B, "Specialty Hospitals and the Stark Act," *Bulletin of the American College of Surgeons*, vol. 88, no. 11, 2003
[7] United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, October 2003

Page 3:
[1,2] Lynk, William J and Longley, Carina S, "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery," *Health Affairs*, vol. 21 no. 4, July/August, 2002
[3] Report to Congress, Office of Inspector General, *DHHS: Financial Arrangements Between Physicians and Health Care Businesses*, pages 18 and 21, May 1989
[4] United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, Oct. 1994
[5] MedPAC, *Assessing adequacy and updating payments for ambulatory surgical center services*, March 2003

Page 4:
[1] "Doctor-owned Specialty Hospitals Spur Investor Interest, Capital Hill Worries," *BNA's Health Care Policy Report*, vol. 11, no.16, 2003
[2] "The Medicare Program Focuses on Outlier Payments to Hospitals," *BNA's Health Care Fraud Report*, vol. 6, no. 24, December 11, 2002; BNA's Medicare Report, vol. 13, no. 47, December 13, 2002
[3] United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 Specialty Hospitals, October 2003

Page 5:
[1] McManis Consulting, *Impacts of Niche Providers on Health Care Delivery*, Presentation to South Dakota Association of Healthcare Organizations Board, July 29, 2004; Note: In August 2004, the facility successfully recruited and employed a neurosurgeon.

Page 6:
[1] American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004
[2,3] State Niche Provider Legislation Overview, American Hospital Association, 2003

Sources:

Chart 1: The Lewin Group analysis of American Hospital Association state survey data, 2004; MedPAC analysis of Provider of Services file, 5% Standard Analytic File of ASC claims from CMS and MedPAC analysis of 5% Standard Analytic File of independent diagnostic testing facility claims from CMS as reported in MedPAC, *Ambulatory Care*, July 2004 (Data not available for all hospitals)

Chart 2: The Lewin Group analysis of American Hospital Association state survey data, 2004

Chart 3: The Lewin Group analysis of American Hospital Association state survey data, 2004; state hospital associations; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Chart 4: United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003; American Association of Ambulatory Surgery Centers ASC Ownership Survey, February 2004

Chart 5: Sec 1877 42USC & 1395nn; Public Law 108-173; 42USC & 1320-a7(b); Saner, RJ, Spindel, MP, and Fitzgerald, M, *New and Clarified Anti-Kickback Safe Harbors Issued*, Powers Pyles Sutter & Verville P.C., http://www.ppsv.com/issues/kickback.htm; Physician Self-Referral Education Resource Web Guide, *Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships*, http://www.cms.hhs.gov/medlearn/refphys.asp; Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE, "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Surgery in States with and without Certificate of Need Regulation," *JAMA*, vol. 288 no. 15, 2002

Chart 6: Lynk, William J and Longley, Carina S, "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery," *Health Affairs*, vol. 21 no. 4, July/August, 2002

Chart 7: United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, Oct. 1994

Chart 8: MedPAC analysis of the 5% Standard Analytic files of ASC and hospital outpatient department claims from CMS as reported in MedPAC, *Ambulatory Surgical Center Services*, March 2004

Chart 9: United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, October 2003

Chart 10: HCA analysis of Houston market data, 2004

Chart 11: United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 Specialty Hospitals, October 2003

Chart 12: United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003

Charts 13 & 14: Data provided by a hospital system in the southwest United States. Relative gains and losses will vary by community based on demographics and payer environment. Net income represents earnings before interest, taxes, depreciation, and amortization at the service level.

Chart 15: The Lewin Group analysis of data from Rapid City Regional Hospital, Rapid City, SD

Chart 16: The Lewin Group analysis of HCRIS data, 2002. Includes 69 limited service providers who had been in operation for at least 2 years (at least one subsequent cost report filed). Community hospitals includes all other PPS hospitals.

Chart 17: The Lewin Group analysis of CMS Provider of Service File, 1Q04 release; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Chart 18: 2003 State Niche Provider Legislation Overview; SC Provider Self-Referral Act, 44-113; American Hospital Association; WA State Hospital Association; Medical Association of GA

TrendWatch is a series of reports produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.

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SENATE PUBLIC HEALTH, WELFARE & SAFETY

EXHIBIT NO. 3

DATE 2-16-05

BILL NO. SB 440

Dear Chairman and members of the Senate Public Health, Welfare and Safety Committee, for the record, my name is Dr. Nick Wolter, Chief Executive Officer of Deaconess Billings Clinic.

DBC is a charitable, tax-exempt medical foundation, employing approximately 2,800 people to operate a 272-bed tertiary hospital, a 200 multi-specialty physician group practice, a 90-bed nursing home, and a research division. DBC also has six regional branch clinic sites in Montana ranging from Bozeman to Miles City as well as two branch sites in Wyoming. We also have affiliate agreements to provide management services to eight rural hospitals and every year, 52 physicians in 18 specialties provide outreach specialty clinics for residents of rural Montana, Wyoming, and North Dakota.

Specialty hospitals have been part of the U.S. health care system for many decades. Hospitals that specialize in care for children, women, eyes, and other medical areas have always been part of the modern medical landscape. What has raised questions and concerns in recent years has been the rapid growth of small, physician-owned hospitals specializing in surgery, cardiac care, and orthopedics; areas known to be highly profitable by hospital administrators. Advances in medical technology, pressure on physician's incomes, and distortions in the payment system have been cited as contributing to these developments.

The Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), responded to the specialty hospital phenomenon and its implications by imposing an 18 month moratorium that effectively halted the development of new physician-owned specialty hospitals. That act also directed MedPAC, an advisory body to Congress, and the Secretary of Health Human Services to report to the Congress on certain issues concerning physician-owned cardiac, orthopedic, and surgical specialty hospitals.

As Deaconess Billings Clinic's chief executive officer, I serve as a MedPAC commissioner. The MedPAC report back to Congress found that:

- Physician-owned specialty hospitals do not have lower costs for Medicare patients than community hospitals.
- They concentrate on particular diagnosis related groups (DRGs) some of which are relatively more profitable than the average, and treat patient who are generally less severe cases.
- They tend to have a lower share of Medicaid patients.

- The financial impact on community hospitals in the markets where physician-owned specialty hospitals are located has been limited, thus far. (Their analysis used 2002 cost and claims data.) Those hospitals have managed to compensate for any losses of patients and revenues and demonstrate financial performance comparable to other community hospitals.
- Some of the incentives for patient selection can be reduced by improving Medicare's acute hospital inpatient payment system.

Physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity and to provide greater satisfaction for them and their patients. They may also be motivated by the financial rewards; some of which may derive from inaccuracies in the Medicare payment system. Their recommendations concentrate on remedying those inaccuracies, which result in the system paying too much for some DRGs relative to others, and too much for patients with relatively less severe conditions. Improving the payment system would help make competition more equitable between community hospitals and physician-owned specialty hospitals, whose physician owners can influence which patients go to which hospital.

MedPAC recommended that CMS should improve the accuracy of Medicare's inpatient acute hospital prospective payment system by:

- Refining the current DRGs to more fully capture differences in severity of illness among patients.
- Basing the DRG relative weights on the estimated cost of providing care rather than on charges.
- Basing the weights on the national average of hospitals' relative values in each DRG.

They also recommended that Congress should extend the current moratorium on specialty hospitals for one year, in order to craft the legislation necessary to address these payment inaccuracies. There will continue to be Federal attention on the issue of physician self-referral for health care services where they have a financial interest. Because this legislation is consistent with these Federal policy recommendations, DBC supports SB 440.
Thank you.

Nicholas Wolter

Source: A forthcoming chapter, *Specialty hospital report*, MedPAC Report to the Congress: Medicare Payment Policy, March 2005.

MONTANA SENATE
2005 LEGISLATURE

ROLL CALL

PUBLIC HEALTH, WELFARE, AND SAFETY

DATE 2-16-05

NAMES	PRESENT	ABSENT	EXCUSED
SEN. BRENT CROMLEY, CHAIRMAN	✓		
SEN. JOHN COBB	✓		
SEN. JOHN ESP	✓		
SEN. DUANE GRIMES	✓		
SEN. LYNDA MOSS	✓		
SEN. JERRY O'NEIL	✓		
SEN. TRUDI SCHMIDT	✓		
SEN. DAN WEINBERG	✓		
SEN. CAROLL WILLAMS	✓		
DAVID NISS, LSD	✓		
RITA TENNESON, COMMITTEE SECRETARY	✓		

MONTANA STATE SENATE
2005 LEGISLATURE

VISITOR REGISTER

PUBLIC HEALTH, WELFARE, AND SAFETY

DATE 2-16-05 **BILLS BEING HEARD TODAY** SB440
SB446

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Jeff Smith	453-1898	Benefis Health System	446		✓
Judy Weista	683-6301	Self	446	✓	
Emily Cooksey	683-5579	Family Services	446	✓	
Jo Smith	682-9348	Family Council	446	✓	
M. Jamison	442-5581	Shodair Hospital	440	✓	
Rachel Smith	453-1899				
Shelri Mahara	461-0896	Lanti's Enterprises	446		✓
Denise Licata	546-8492	Sage Co	446		✓
DeAnn Smallwood	728-9162	Village Health Care Center	446		✓
BEV McCOY	683-2980	100 SPRING CREEK RD	446	✓	✓
Erin Garlinghouse	782-5555	Assoc Reimbursement Mgrs	446	✓	
KATHLEEN DOUGHTY	442-6990	MT Nurses Assn	446	✓	
LaDawn Muir	453-4142	Central Montana Surgical Hosp	440		✓
Arla Blount	454-6990	Ombudsman	446	✓	
Alana Kietzmann	454-6990	Ombudsman	446	✓	
Anna Kietzman	454-6990	Ombudsman	446	✓	
Betty Beverly	443-5341	MSCA	446	✓	
Mike Foster	237-3038	SVH, SJH, HRH, WMH	440	✓	
James Kiser	723-2449	St. James Healthcare Butte	440	✓	
Claudia Clifford	457-4705	AARP	446	✓	
John Colheim	444-2160	St. Peters Hospital	440	✓	
Jami McGill	670-3084	OSC	446	✓	✓
John Flink	442-1911	MHA	440	✓	

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MONTANA STATE SENATE
2005 LEGISLATURE

VISITOR REGISTER

PUBLIC HEALTH, WELFARE, AND SAFETY

DATE 2-16-05 **BILLS BEING HEARD TODAY** SB 440, 446

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Rose Hughes	443-2876	MT Health Care Assn	446		X
Pat Melby	442-7450	MT Med Ass'n	446		✓
" "	"	" " "	440		✓
Bill Tash		SD 36	446		✓

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

MONTANA SENATE
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN BRENT R. CROMLEY**, on February 18, 2005 at 3:20 P.M., in Room 317 Capitol.

ROLL CALL

Members Present:

Sen. Brent R. Cromley, Chairman (D)
Sen. John Cobb (R)
Sen. John Esp (R)
Sen. Duane Grimes (R)
Sen. Lynda Moss (D)
Sen. Jerry O'Neil (R)
Sen. Trudi Schmidt (D)
Sen. Dan Weinberg (D)
Sen. Carol Williams (D)

Members Excused: None.

Members Absent: None.

Staff Present: David Niss, Legislative Branch
Rita Tenneson, Committee Secretary

Please Note. These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing & Date Posted:	SB 448, 2/14/2005; SB 467, 2/14/2005; SB 499, 2/16/2005; SJ 28, 2/17/2005; SB 479, 2/15/2005
Executive Action:	SB 467; SJ 28; SB 479; SB 440 SB 448; SB 499

Dennis McSweeney, practice manager for a Helena pathology group, read his testimony in favor of the bill.

EXHIBIT(phs40a26)

Jeffrey K. Smith, MD, President, Montana Society of Pathologists, submitted written testimony in favor.

EXHIBIT(phs40a27)

Ben Blend, MD, pathologist, Bozeman Deaconess Hospital, with written testimony in favor.

EXHIBIT(phs40a28)

Opponents' Testimony: None.

Informational Testimony: None.

Questions from Committee Members and Responses:

SEN. O'NEIL asked **SEN. LIND** if it would be fair to only allow hospitals to do the lab work. **SEN. LIND** said this bill prohibits one physician from billing a lab in which he or she has an interest. They are trying to eliminate a middleman. Some physicians own their own labs. This bill doesn't allow them to bill their own lab and then bill the patient at a mark up. It does allow them to bill other physicians who have work done in their lab.

Closing by Sponsor:

SEN LIND, in closing, said when the physician, who does the biopsy, sends it out of State at a discount, then bills the patient with a mark-up, it is contrary to the MMA's ethics. This physician is marking up their bill.

EXECUTIVE ACTION ON SB 479

Motion/Vote: **SEN. GRIMES moved that SB 479 DO PASS. Motion carried unanimously by voice vote.**

EXECUTIVE ACTION ON SB 440

This is **SEN. HARRINGTON'S** bill for licensing specialty hospitals.

Motion: **SEN. MOSS moved that SB 440 DO PASS.**

Motion/Vote: **SEN. ESP moved that AMENDMENT SB 044002.adn DO PASS. Motion carried unanimously by voice vote.**

EXHIBIT(phs40a29)

Motion/Vote: **SEN. MOSS moved that SB 440 DO PASS AS AMENDED. Motion carried 7-2 by voice vote with SEN. COBB and SEN. O'NEIL voting no.**

EXECUTIVE ACTION ON SB 448

Motion: **SEN. ESP moved that SB 448 DO PASS.**

Discussion: **SEN. ESP** presented an amendment to clarify that the total practice cannot exceed its own scope of practice outside the door of the hospital. This extends the scope of practice to the emergency room.

SEN. O'NEIL said the EMT could give a transfusion in the ambulance. Could he give a transfusion inside the emergency room. **SEN. ESP** said it was an allowable. Under the stop of practice outside the emergency room, he could not.

Mr. Niss said the amendment was on page 1, lines 28 and 29. On line 28 put "and" before protocols, and delete after protocols "and the scope of practice". On line 29, after the period insert the rules may not expand the rules of practice but may allow the application of those practices in the hospital."

SEN. WILLIAMS expressed concern about the stop of practice and the nurses' association. She wanted to hear their comments on narrowing the practice. **Mrs. Haworth** told her right now an EMT can be employed as an emergency technician. Under the job description they believe this is adequate, but there are some changes in what that technician can do.

SEN. ESP said the concern expressed in the hearing was whether the Board had the ability to rule. One of the concerns was that their responsibility could be greater. It is hard to understand. The amendment makes it clear they can't expand the EMT's services over someone who has the same classification

SEN. GRIMES thought that was what they wanted to do. **SEN. ESP** said they want to keep the same practice.

MONTANA SENATE
2005 LEGISLATURE

ROLL CALL

PUBLIC HEALTH, WELFARE, AND SAFETY

DATE 2/18/05

NAMES	PRESENT	ABSENT	EXCUSED
SEN. BRENT CROMLEY, CHAIRMAN	✓		
SEN. JOHN COBB	✓		
SEN. JOHN ESP	✓		
SEN. DUANE GRIMES	✓		
SEN. LYNDA MOSS	✓		
SEN. JERRY O'NEIL	✓		
SEN. TRUDI SCHMIDT	✓		
SEN. DAN WEINBERG	✓		
SEN. CAROLL WILLAMS	✓		
DAVID NISS, LSD	✓		
RITA TENNESON, COMMITTEE SECRETARY	✓		

SENATE STANDING COMMITTEE REPORT

Mr. President:

We, your committee on **Public Health, Welfare and Safety** recommend that **Senate Bill 440** (first reading copy -- white) **do pass as amended.**

Signed: _____
Senator Brent R. Cromley, Chair

And, that such amendments read:

1. Title, line 8.
Following: "DATE"
Insert: ", AN APPLICABILITY DATE, AND A TERMINATION DATE"

2. Page 8, line 9.
Following: "hospitals"
Insert: "using the requirements for licensure of hospitals and the procedure provided for in parts 1 and 2 of this chapter"

3. Page 8, line 10 through line 18.
Strike: subsection (2) in its entirety
Renumber: subsequent subsections

4. Page 8, line 21.
Strike: "subsections (1) and (2)"
Insert: "subsection (1)"

5. Page 9.
Following: line 2
Insert: "NEW SECTION. **Section 5. Applicability.** [This act] applies to specialty hospitals to be established after the

Committee Vote:
Yes 7, No 2.

420940SC.sjo

moratorium on referrals to specialty hospitals referred to in [section 4] expires."

Insert: "NEW SECTION. **Section 6. Termination.** [This act] terminates July 1, 2007."

- END -

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES

Call to Order: By **CHAIRMAN ARLENE BECKER**, on March 21, 2005 at 3:00 P.M., in Room 472 Capitol.

ROLL CALL

Members Present:

Rep. Arlene Becker, Chairman (D)
Rep. Tom Facey, Vice Chairman (D)
Rep. Don Roberts, Vice Chairman (R)
Rep. Mary Caferro (D)
Rep. Emelie Eaton (D)
Rep. Gordon R. Hendrick (R)
Rep. Teresa K. Henry (D)
Rep. William J. Jones (R)
Rep. Dave McAlpin (D)
Rep. Tom McGillvray (R)
Rep. Mike Milburn (R)
Rep. Art Noonan (D)
Rep. Ron Stoker (R)
Rep. Pat Wagman (R)
Rep. Bill Warden (R)
Rep. Jonathan Windy Boy (D)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Branch
Mary Gay Wells, Committee Secretary

Please Note. These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing & Date Posted:	SB 33, 3/12/2005; SB 82, 3/12/2005; SB 440, 3/12/2005;
Executive Action:	SB 21, Be Concurred In SB 322, Be Concurred In SB 479, Be Concurred In

HEARING ON SB 440

Sponsor: **SEN. DAN HARRINGTON, SD 38, BUTTE**

Opening Statement by Sponsor:

SEN. JON TESTER, SD 15, opened the hearing for **SEN. DAN HARRINGTON** on **SB 440** which would require licensure of specialty hospitals. There is no fiscal note. On Page 8, Line 1, a specialty hospital is defined. On Page 8, Lines 8-9, the requirements are put forth for licensure of a specialty hospital. There is a termination date of July 1, 2007.

Proponents' Testimony:

REP. ART NOONAN, HD 73, said that they had an experience in Butte in dealing with a specialty hospital. Generally, if there is a big enough market place, these hospitals which are normally owned by physicians and deal with very specific types of surgery, can increase competition and be very good for the general market place. However, in Montana, there is a system of community hospitals that are the safety net that hold up the communities. In Montana communities, specialty hospitals can cause economic dislocation. The Federal Government is undertaking the task of producing a policy to deal with specialty hospitals. This bill places a moratorium of July 1, 2007 on these hospitals until the Federal studies have been completed.
{Tape: 2; Side: A; Approx. Time Counter: 7.4 - 11.1}

James Kaiser, Hospital Administrator, St. James Health Care, Butte, said there is a misunderstanding that this is an issue of competition. It is a matter of the common good. A typical hospital has a professional component, the physician, and the technical component, the hospital. The healthcare system is flawed especially in how it gets paid for. There are services that are profitable and those are used to subsidize the costs that are not covered. This bill would only come into play if the Federal bill is not passed to extend the moratorium.

Tom Ebzery, Attorney, St. Vincent Health Care, Billings, Holy Rosary Health Care, Miles City and Wheatland Memorial, Harlowton, said that SB 440 is an important bill. Congress has been wrestling with the issue of for-profit specialty hospitals and the potentially devastating impact on non-profit community hospitals. This bill essentially adopts the recommendation of extending the moratorium and further extends the moratorium another six months to July 1, 2007. He pointed out that the two existing limited services hospitals in Montana, one in Kalispell

and one in Great Falls, are not affected by this legislation as they are provided with an exception to the moratorium through a grandfather provision that is in the bill.
{Tape: 2; Side: A; Approx. Time Counter: 11.1 - 16.8}

John Flink, Montana Hospital Association, stood in support of the bill and urged a concurrence.

Opponents' Testimony: None

Informational Testimony:

Mary Dalton, Quality Assurance Division, DPHHS, said she was in attendance to answer any questions.

Questions from Committee Members and Responses:

REP. ROBERTS questioned why the words "certificate of need" were not in the bill. **Mr. Kaiser** did not think a "certificate of need" arises when there is a level playing field in the effect that if one has the service already, is another one needed. They would not duplicate the services being provided. It would only duplicate profitable services.

REP. ROBERTS asked if the facilities that become specialty hospitals offer emergency care. **Mr. Kaiser** answered, "Not typically." They realize that is often a request, so they do it in name only and seldom staff it. It is the same with OB services. Sixty to 80 percent of community hospital deliveries are Medicaid.

REP. ROBERTS asked if 60% to 70% of hospitals' reimbursements are from Federal programs like Medicaid and Medicare. **Mr. Kaiser** replied that without the commercial insurer and the cost shifting that occurs, they would be operating in the red. They have experienced two years of volumes that are higher than anticipated. Sadly, their uncompensated care, such as charity care and bad debt, has gone from four percent from two years ago to ten percent. They are operating on a thread.
{Tape: 2; Side: A; Approx. Time Counter: 16.8 - 21}

REP. FACEY asked Mr. Flink's opinion of the bill. **Mr. Flink** replied that his Association strongly supports the bill. They helped put it together. This is an issue that should be solved at the Federal level.

REP. STOKER inquired how many of these specialty hospitals are currently licensed. **Ms. Dalton** responded that two are licensed,

but currently there is no category for specialty hospitals. They are licensed as a hospital.

REP. STOKER asked which two hospitals are being referred to. **Ms. Dalton** replied that they are Health Center Northwest in Kalispell and Central Montana Surgical in Great Falls.

REP. STOKER asked if these two for-profit hospitals would be secure under their current licensing even after the July 1, 2007 date. **Ms. Dalton** responded that they would be secure, but she had not considered if the two hospitals would have to convert to another type of license after July 1, 2007.

REP. STOKER understood the concern of the non-profit hospitals; but if the flip side comes about, would they become bankrupt or non-profit as well. **Ms. Dalton** said that non-profit hospitals are able to provide some limited services of a specialty hospital. They would not have to become any broader than they are right now.
{Tape: 2; Side: A; Approx. Time Counter: 21 - 25.1}

Ms. Fox explained that the bill will terminate on July 1, 2007. The applicability clause states that specialty hospitals would be established after the moratorium on referrals to specialty hospitals referred to in (Section 4) expires. It is staggered. First the bill has to be put into effect by the contingency in Section 4. It only affects hospitals established after the fact. The two hospitals are grandfathered in permanently. When the law terminates in 2007, the Legislature will have to deal with it again.

REP. FACEY asked Ms. Dalton to explain the difference between a hospital, a specialty hospital and a stand-alone surgery center. **Ms. Dalton** said that a specialty hospital is primarily engaged in care and treatment for either patients with a cardiac condition, an orthopedic condition, patients receiving surgical procedure, or other specialized categories of service. A hospital in Montana must offer organized medical staff on call and available within 20 minutes, 24 hours a day, seven days a week, and provide 24-hour nursing care by licensed and registered nurses. She continued in her explanation. The stand-alone surgery centers are not hospitals. They do not have overnight care.

REP. FACEY asked about a bill that would have allowed the out-patient surgery centers to go to 72 hours. **Mr. Flink** said that bill did not pass and the stay in an out-patient surgery center was 24 hours. They are licensed separately from hospitals.
{Tape: 2; Side: A; Approx. Time Counter: 25.1 - 32}

REP. HENDRICK wondered how this bill would affect the critical access hospitals in the rural areas. **Mr. Flink** responded that this bill would not affect them at all.

REP. HENDRICK questioned the date of termination on Page 8, Line 22. **Ms. Fox** said that if the bill terminates on July 1, 2007, anyone could get a specialty hospital license unless the Federal Government passes further law concerning specialty hospitals.

CHAIRMAN BECKER stated that the bill puts a moratorium on in Montana until July 1, 2007 and basically, the next Legislative Session has to deal with it again.

Ms. Fox agreed but added it will depend on what the Federal Government does.

Closing by Sponsor:

The Sponsor closed.

REP. NOONAN will carry the bill.
{Tape: 2; Side: B; Approx. Time Counter: 0 - 4.3}

EXECUTIVE ACTION ON HB 449

Motion: **REP. FACEY moved that HB 449 DO PASS.**

Discussion:

There was a great deal of discussion about the bill. The bill addressed at-home infant care. Currently, there is no funding for this program. This bill directs that state funding would be made available. There was an amendment by REP. CAFERRO which would have allowed the law to be changed to say that if there is state funding available, then the program would go forward.

At the time a vote would have been taken on the amendment, REP. CAFERRO asked that the proceedings cease because REP. ROBERTS was not at the hearing any longer and she did not think that the proxy vote was what he would have wanted.

All motions were withdrawn without objection and the meeting adjourned.
{Tape: 2; Side: B; Approx. Time Counter: 4.3 - 12.5}

HOUSE OF REPRESENTATIVES
Roll Call
HUMAN SERVICES COMMITTEE

DATE 3-21-05

NAME	PRESENT	ABSENT	EXCUSED
REP. ARLENE BECKER, CHAIR	X		
REP. TOM FACEY, VICE CHAIR	X		
REP. DON ROBERTS, VICE CHAIR	X		
REP. MARY CAFERRO	X		
REP. EMELIE EATON	X		
REP. GORDON HENDRICK	X		
REP. TERESA HENRY	X		
REP. WILLIAM JONES	X		
REP. DAVE McALPIN	X		
REP. TOM McGILLVRAY	X		
REP. MIKE MILBURN	X		
REP. ART NOONAN	X		
REP. RON STOKER	X		
REP. PAT WAGMAN	X		
REP. BILL WARDEN	X		
REP. JONATHAN WINDY BOY	X		

Montana House of Representatives
Visitors Register

HUMAN SERVICES COMMITTEE **Date** 3-21-05

Bill No. SB-440 **Sponsor(s)** Sen D. Harrington

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

Name and Address	Representing	Support	Oppose	Inf.
Mary Dalton	DPHHS			X
Jane McCall	DOC	✓		
James Kiser	St. James Healthcare	✓		
Tom Ebzery	St Vincent Healthcare	✓		
Pat Melby	MT Med Ass'n		✓	

Please leave prepared testimony with Secretary. Witness Statement forms are available if you care to submit written testimony.

/s/HumServVisitorReg.sample2003

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
59th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES

Call to Order: By **CHAIRMAN ARLENE BECKER**, on April 4, 2005 at 3:00 P.M., in Room 472 Capitol.

ROLL CALL

Members Present:

Rep. Arlene Becker, Chairman (D)
Rep. Tom Facey, Vice Chairman (D)
Rep. Don Roberts, Vice Chairman (R)
Rep. Emelie Eaton (D)
Rep. Gordon R. Hendrick (R)
Rep. Teresa K. Henry (D)
Rep. William J. Jones (R)
Rep. Dave McAlpin (D)
Rep. Tom McGillvray (R)
Rep. Mike Milburn (R)
Rep. Art Noonan (D)
Rep. Ron Stoker (R)
Rep. Pat Wagman (R)
Rep. Bill Warden (R)
Rep. Jonathan Windy Boy (D)

Members Excused: Rep. Mary Caferro (D)

Members Absent: None.

Staff Present: Susan Fox, Legislative Branch
Mary Gay Wells, Committee Secretary

Please Note. These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing & Date Posted: SJ 13, 3/13/2005
SJ 26, 3/31/2005
SJ 27, 3/31/2005
SB 287, 3/31/2005
SB 358, 3/31/2005

Executive Action:
SJ 13 Be Concurred In
SJ 26 Be Concurred In
SJ 27 Be Concurred In
SB 86 Be Concurred In
SB 358 Be Concurred In
SB 440 Be Concurred In
SB 287 Be Concurred In As Amended

HEARING ON SB 358

Sponsor: **SEN. BOB KEENAN, SD 5, BIGFORK**

Opening Statement by Sponsor:

SEN. BOB KEENAN opened the hearing on **SB 358.** He gave a history of the bill which goes back to 1997. SB 69 would have authorized the Department of Public Health and Human Services (DPHHS) to develop a long-term care insurance partnership if certain changes had happened in Federal law. Those changes did not happen. This bill would allow DPHHS to seek authority through a waiver to implement the long-term care insurance partnership. As part of the Medicaid Redesign Committee, they talked about this approach and recommended this bill be brought forward. It encourages people to buy long-term care insurance.

Proponents' Testimony:

Erin McGowan-Fincham, State Auditor's Office, said that the Auditor's Office was in support of the bill. She handed out a brochure from the State Auditor. This partnership would encourage more Montanans to purchase long-term care insurance. The pricing is approximately $170 per year for a 45 year old for a minimum benefit policy. It would be almost double for a higher benefit policy. For a person over 60 years, the price is closer to $5,000 per year.
EXHIBIT(huh71a01)
{Tape: 1; Side: A; Approx. Time Counter: 0 - 6.1}

Opponents' Testimony: None

Informational Testimony: None

Questions from Committee Members and Responses:

REP. TOM MCGILLVRAY inquired if this insurance would be a dollar for dollar offset and up to how much. **SEN. KEENAN** thought it was up to $200,000.

EXECUTIVE ACTION ON SJ 27

Motion/Vote: REP. FACEY moved that SJ 27 BE CONCURRED IN. Motion carried unanimously by voice vote 16-0. REP. CAFERRO and REP. MILBURN voted by proxy.

REP. NOONAN will carry the bill.

EXECUTIVE ACTION ON SB 440

Motion: REP. ROBERTS moved that SB 440 BE CONCURRED IN.

Discussion:

REP. ROBERTS explained the bill. Specialty hospitals are becoming a popular entity in large cities. Training hospitals are left picking up everything else. Unfortunately, the hospitals that are losing the specialty cases have to pay for the indigents who go to the emergency rooms, etc.

Vote: Motion carried unanimously by voice vote 16-0. REP. CAFERRO and REP. MILBURN voted by proxy.

REP. FACEY will carry the bill.
{Tape: 3; Side: A; Approx. Time Counter: 17 - 21.6}

EXECUTIVE ACTION ON SB 358

Motion/Vote: REP. FACEY moved that SB 358 BE CONCURRED IN. Motion carried unanimously by voice vote 16-0. REP. CAFERRO and REP. MILBURN voted by proxy.

REP. MCGILLVRAY will carry the bill.

EXECUTIVE ACTION ON SB 86

Motion: REP. WINDY BOY moved that SB 86 BE CONCURRED IN.

HOUSE OF REPRESENTATIVES
Roll Call
HUMAN SERVICES COMMITTEE

DATE 4-4-05

NAME	PRESENT	ABSENT	EXCUSED
REP. ARLENE BECKER, CHAIR	X		
REP. TOM FACEY, VICE CHAIR	X		
REP. DON ROBERTS, VICE CHAIR	X		
REP. MARY CAFERRO			X
REP. EMELIE EATON	X		
REP. GORDON HENDRICK	X		
REP. TERESA HENRY	X		
REP. WILLIAM JONES	X		
REP. DAVE McALPIN	X		
REP. TOM McGILLVRAY	X		
REP. MIKE MILBURN	X		
REP. ART NOONAN	X		
REP. RON STOKER	X		
REP. PAT WAGMAN	X		
REP. BILL WARDEN	X		
REP. JONATHAN WINDY BOY	X		

HOUSE STANDING COMMITTEE REPORT

Mr. Speaker:

We, your committee on **Human Services** recommend that **Senate Bill 440** (third reading copy -- blue) **be concurred in**.

Signed: Arlene Becker
Representative Arlene Becker, Chair

To be carried by Representative Tom Facey

- END -

Committee Vote:
Yes 16, No 0.

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4/15/05